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	085040	A. BUILDING _____ B. WING _____	C 02/15/2017

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F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from February 8, 2017 through February 15, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 106. The survey sample totaled thirty four (34). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; SW - Social Worker; OT - Occupational Therapist PT - Physical Therapist; COTA - Certified Occupational Therapy Assistant; AO x 3 (Alert and oriented times 3) - fully alert and oriented to self, place and time; Abduction - movement of a limb or body part farther from the midline of the body OR turning outward; Adduction-movement toward the midline of the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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body;
Abrasion - wearing away of the skin through some mechanical process (friction or trauma) OR superficial wound caused by rubbing or scraping the skin;
ADLs (Activities of Daily Living) - activities such as bathing and dressing;
Alzheimer's Disease - degenerative brain disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language and poor judgement, personality changes and confusion;
ASAP - As soon as possible;
Aseptic technique - following a clean (not sterile) process for wound care;
BID - Twice a day;
BLE - Bilateral (both) lower extremities;
Bruise - injury causing rupture of underlying blood vessels with resultant discoloration;
cm (centimeter) - metric unit of size measurement of length, equal to one hundredth of a meter and 1 centimeter = 0.39 inches;
CMS - abbreviation for Centers for Medicare and Medicaid Services, an agency of the U.S. Department of Health and Human Services;
Comorbidities - presence of two or more chronic diseases;
Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten;
Cognition - mental process, thinking, memory;
Contusion - a region of injured tissue in which blood capillaries have been ruptured, a bruise;
Degenerative joint disease - osteoarthritis or degenerative arthritis, a condition that develops as joints wear down with age and use causing stiffness and discomfort;
Dementia - brain disorder with memory loss, poor judgement, personality changes and confusion;
DLTCRP - the Delaware Division of Long Term Care Residents Protection;

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Doppler ultrasound - blood flow studies can detect abnormal blood flow with in a blood vessel;
Dry heaves - a sensation you feel when you are about to vomit but nothing comes out of your mouth;
eMAR - Electronic Medication Administration Record (in the computer);
EMR - Electronic Medical Record;
etc (et cetera) -and so forth;
Extension - straightening of an extremity or joint;
F (Fahrenheit) - a measure (degrees) of temperature used by most people in the United States;
Foot drop board - upright panel supporting the foot on the wheelchair;
Functional quadriplegia - the complete inability to move due to severe disability or frailty caused by a medical condition;
Hemiplegia - half of the body paralyzed (right or left);
Hospice - service that provides care to residents who are terminally ill;
HS - At bedtime;
Immobility - not being able to move around;
i.e.- that is;
Injectable - a liquid form of a medication that can be forced into the bloodstream or body tissue;
lateral - side;
MAR - Medication Administration Record a monthly document where nurses document medications administered to residents;
Maintenance Program - skilled care to prevent or slow a decline in condition;
MDS - Minimum Data Set (standardized assessment used in nursing homes and submitted to Medicare);
Mechanical lift - an assistive transfer device that allows residents to be moved between a bed and a chair or stretcher using hydraulic power lift and

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sling;
Medicaid - a health insurance program for low-income individuals and those with disabilities financed by the state and federal governments;
mg (milligrams) - metric unit of weight;
-Minus;
O x 0 (Orientation times Zero) - resident who does not know to him/her self, where s/he is place or the time;
ODT - Orally Dissolving Tablets;
OOB - Out of bed;
OT (Occupational Therapy) - rehabilitation needed for completion of ADLs;
Quadriplegia - the complete inability to move due to severe disability or frailty caused by a medical condition;
Palliative care - care for residents who have serious illnesses which focuses on symptom management and improving quality of life and can be combined with curative treatment;
Phenergan-medication used to treat nausea and vomiting;
POS - Physician Order Sheet - monthly report of active physician orders;
PO - Physician's Order;
po - by mouth;
PU (Pressure Ulcers) - sore area of skin that develops when blood supply is cut off due to pressure;
PRN - as needed;
Prognosis - prediction of the probable course and outcome of a disease;
PROM - Passive Range of Motion-Joint movement by staff;
PT - physical therapy;
Rehabilitation - treatment for recovery from injury or disease;
RNP (Restorative Nursing Program) - nursing interventions promote residents;ability to adjust to

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F 000	Continued From page 4 living as independently and safely as possible; ROM (Range of motion) - extent to which a joint can be moved safely; Spinal stenosis - pain caused by compression on spinal nerves; STAT- immediately; TAR - Electronic Treatment Administration Record (in the computer); TID - Three times a day; TO - telephone order from a practitioner; Ultrasound - blood flow studies can detect abnormal blood flow with in a blood vessel; Q-tip - cotton tipped non sterile applicator used for wound care; VO - verbal order from a practitioner; X - Times or by; Zofran ODT - medication that dissolves on the tongue to treat nausea; 90 degree angle- is a right angle; right angle is an angle that bisects the angle formed by two adjacent parts of a straight line.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 272		3/31/17

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F 272	Continued From page 5 (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R165) out of 34 sampled residents the facility failed to ensure the comprehensive assessment was accurate. Findings include:	F 272	A. R165 MDS was corrected on 2/13/2017. B. The MDS of current residents receiving hospice services were reviewed and corrections were done by 2/16/2017.	

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F 272	Continued From page 6 The following was reviewed in R165's clinical record: R165 was admitted to the facility on 8/11/16 on Hospice services. 8/18/16 - Admission MDS documented the resident had a prognosis of 6 months or less to live but did not assess the presence of Hospice services. 11/18/16 - Quarterly MDS did not document the end of life prognosis or the presence of Hospice services. An interview on 2/13/17 at 2:25 PM with E16 (RNAC) revealed the above assessments were not accurate in the area of Hospice / prognosis. It was confirmed that R165 had been on Hospice since admission with a prognosis of less then 6 months. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/15/17 at 3:00 PM.	F 272	C. Education using pages J-23, J-24, O-1, and O-4 from the Resident Assessment Instrument Manual for the MDS which covers sections J and O for accurate MDS coding for end of life and hospice services was completed on 2/20/17 with current RNs completing these sections (Attachment A). D. The Center Nurse Executive/designee will complete MDS audits (Attachment B) of all hospice residents for accuracy of sections J & O weekly until 100% compliance on 3 consecutive evaluations, then monthly until 100% compliance on 3 consecutive evaluations. Results of the audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care	F 309		3/31/17

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F 309	Continued From page 7 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R222 and R16) out of 34 sampled residents the facility failed to provide the necessary care and services according to the plan of care to attain or maintain the highest practicable physical, mental, and psychosocial well-being. R222's vital signs were not assessed as ordered. R11 with complaints of nausea, did not receive a medication for nausea for over 24 hours after the medication was ordered. Findings include: 1. The following was reviewed in R222's clinical record:	F 309	A. R222 was discharged from facility on 6/12/16. R16 has current care plan and medication in place for nausea as needed. B. Current residents with orders for vitals every shift were reviewed for accuracy of documentation. Current residents with nausea care plans were reviewed and all residents with nausea care plans currently have an as needed medication available. C. A root cause analysis was completed on 3/6/17 on resident with missing vitals	

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F 309	Continued From page 8 5/13/16 - Physician's order to monitor vital signs every shift for 72 hours and notify nurse practitioner if the temperature is above 99.5 degrees F. The following vital signs including temperature were found: 5/13 3:02 PM - day shift 5/14 12:30 AM - night shift 5/15 12:50 AM - night shift 5/15 11:22 AM - day shift 5/16 1:28 AM - night shift After review of the medical record there was no evidence that 4 of the 9 vital sign assessments were completed. The missing dates were 5/13 evening, 5/14 day, 5/14 evening, 5/15 evening. During an interview on 2/15/17 at 12:48 PM, E2 (DON) revealed the remaining 4 vital signs could not be located. 2. Review of R16's clinical record revealed: 12/2/15 (1:35 PM) - NP telephone order written for a medication for nausea (Zofran) to be dissolved on the tongue (ODT) every 8 hours PRN for nausea or vomiting. 12/2/15 (3:36 PM) Change of Condition Nursing Note - R16 had weakness along with nausea and vomiting and was only able to tolerate drinking a few sips of fluid. NP notified and order for PRN nausea medication received (see above). 12/2/15 (10:36 PM) Nursing Note - no vomiting, still complaining of nausea, refusing to eat but would take sips of liquids.	F 309	when ordered every shift for 72 hours and on order for Zofran taking over 12 hours to order the medication and then over 25 hours in receipt of the medication. A new process was developed for every shift vitals ordered being done at 1000, 1800, and 0200 and a vital signs worksheet was developed and will be utilized (Attachment C). In addition, the nursing process will be to place the vitals on the Medication Administration Record to include a note to document in Point Click Care which is the electronic resident record. A Change in Condition Worksheet was developed for nurses as a reference for vitals needed after a change in residents' condition (Attachment D). The quick reference tool of medications available in the on-site Omnicell was updated on 3/9/17 and will be utilized by nursing to request medication order from the physician that can be given immediately until original medication is received from the pharmacy (Attachment E). Zofran (Ondansetron HCL) oral medication is now available in the on-site Omnicell. Education regarding the new processes and details of documentation in the clinical record will be completed by 3/24/17 (Attachment F). D. The Center Nurse Executive/designee will complete daily audits of residents with orders for every shift vitals (Attachment G)and residents with documented nausea in the clinical record (Attachment H) until 100% compliance is achieved on 3 consecutive evaluations. Then audits will occur weekly until 100% compliance is achieved on 3 consecutive evaluations,	

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F 309	Continued From page 9 Review of December, 2015 MARs and nursing notes found no evidence that the resident received or refused the PRN medication for nausea on or if an alternative treatment was considered if the ordered medication was not available. 12/3/15 (3:31 AM and 11:31 AM) Nursing Notes - no nausea. December, 2015 - MAR documented the resident received 1 dose of medication for nausea on 12/3/15 at 7:00 PM, over 29 hours after the order was written. 12/4/15 NP Note - Informed that R16 experienced dry heaves (no vomiting) today but did not receive any nausea medication. During an interview with E4 (RN, UM) on 2/15/17 at 10:35 AM to discuss the untreated nausea, E4 reviewed in the medical record/EMR the medication orders, NP notes, nursing notes, vital signs, weights and physician note (none) between November 30 through December 4, 2015. E4 confirmed the PRN medication for nausea was not given until 29 hours after the order was written. When asked about PRN nausea medications available at the facility, E4 showed that currently two injectable medications (including injectable version of the medication ordered) were available. E4 said she will determine the PRN drugs for nausea that were available in December 2015 and evidence of when the ordered Zofran was delivered. 12/15/17 Pharmacy Operations Manager email sent to E4 at 12:18 PM - the order for the nausea	F 309	and then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 309	Continued From page 10 medication was received 12/3/15 at 1:23 AM [a delay of 12 hours after the order was written]. The medication was processed for the first delivery and received at the facility on 12/3/16 at 3:02 PM [more than 25 hours after the order was written]. Review of documents and interviews revealed there was a: - 12 hour delay in ordering the medication, - 25 hour delay in receipt of the medication - Failure of the facility to contact NP/MD for an alternative medication/formulation to be given to relieve the nausea. Besides a 12-hour delay in sending the medication order to the pharmacy, the facility failed to contact the NP to determine if another form (such as an injectable medication which was available) would be an appropriate intervention to treat the resident's nausea. R11 did not receive the medication for over 24 hours after the medication was ordered. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/15/17 at 3:00 PM.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 314		3/31/17

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F 314	Continued From page 11 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documents it was determined that for one (R182) out of 34 sampled residents the facility failed to ensure a PU treatment was conducted in a manner that prevented infection. Findings include: The facility's policy for Wound Dressings: Aseptic (clean) included the following: - If a break in aseptic technique occurs, stop procedure, remove gloves, cleanse hands, and apply clean gloves. During an observation of R182's PU treatment on 2/15/17 between 10:40 AM and 11:40 AM the following were observed: - Although E14 cleaned the table to be used for supplies s/he failed to open the packaged supplies on the clean field to prevent them from touching the potentially contaminated packaging during the treatment. - E14 washed hands, donned new gloves then proceeded to unhook the wound machine and touched the resident's pillow contaminating her hands before removing the old wound dressing which included using a Q-tip and her fingers to	F 314	A. R182 was discharged home on 3/4/17. B. Current residents receiving treatment for wound care have the potential to be affected. C. A root cause analysis was completed on 3/6/17 to determine underlying cause for why employee did not follow proper procedure for wound care. A new process is being implemented for a wound care observation competency. Education will be completed with all nurses on the wound care policy by 3/24/17(Attachment F), and wound care observation competencies will be completed for all nurses at least annually. D. The Center Nurse Executive/designee will complete daily wound care observation audits (Attachment I) of 10% of residents with wound care treatments until 100% compliance is achieved on 3 consecutive evaluations. Then audits will occur weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the	

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F 314	Continued From page 12 remove wound packing. - E14 washed hands and donned new gloves after removing the old dressing, while returning to the bedside E14 used her gloved hands to open and close the privacy curtain, contaminating her hands again. E14 then proceeded to open the packages of treatment materials and pulled supplies out of a plastic storage bag to be used during the treatment. E14 used the same gloved hands to measure the wound, hold the foam dressing that s/he was cutting to size and placing the foam into the wound with the guidance of a Q-tip. At the conclusion of the treatment these breeches in infection prevention were reviewed with E14, who stated she washed her hands several times during the treatment. These findings were reviewed with E1 (NHA) and E2 (DON) on 2/15/17 at 3:00 PM.	F 314	Quality Assurance Performance Improvement Committee for review and recommendations.	
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 318		3/31/17

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F 318	Continued From page 13 by: Based on record review, observation and interview it was determined that the facility failed to implement OT recommendations to assure that one (R11) out of 34 sampled residents received treatments and services to prevent a further decrease in range of motion. The order for R11's left elbow splint was never written or implemented for multiple occasions. The foot drop board was not consistently placed on the resident's wheelchair. Findings include: Review of R11's clinical record revealed: 10/11/02 - Admission to facility with multiple diagnoses including Alzheimer's Disease, arthritis and abnormal posture. Review of Range of Motion Measurement forms found the following about the left elbow extension measurements followed by severity range (5 degree variance plus or minus accepted between therapist): - 3/19/10: moderate/severe contracture at -50 degrees (moderate 25-50; severe 51-80). - 4/6/11: moderate at -30 degrees which was an improvement from the previous year (moderate 25-50, minimal 5-30). 11/14/12 Care Plan-(reviewed quarterly, last revised 11/21/12) - Care plan problem for actual ROM deficit related to decreased cognitive status and decreased functional ability included the goal that R11 would not decrease in functional status associated with ROM deficits. Interventions included: Notify PT/OT for evaluation if decline in functional status noted; Perform contracture measurements as per OT/PT recommendations; Position upper extremities in extension and	F 318	A. R11 was assessed by licensed therapist on 2/14/17 and care plan currently reflects accurate range of motion program. B. Current residents with range of motion, splints and footboard have the potential to be affected. List of residents with splints and footboard were reviewed and care plans and tasks are in place. C. A root cause analysis was conducted on 3/6/17 regarding range of motion to include footboard and splint usage. Education will be completed by 3/24/17 for all clinical staff regarding the process of communicating therapy recommendations for interventions to prevent decrease in range of motion (Attachment F). Therapists will provide recommendations to the unit manager who will in turn update the plan of care. The Therapy Communication Tool was updated to include footboard (Attachment J). The Splint Wearing Instruction form (Attachment K) will be completed by therapists and also provided to unit managers for updating plans of care. Both forms will be placed inside the resident wardrobe/closet as a quick reference for staff assisting with resident care. A new process for therapy was implemented as follows: evaluation and treatment orders written for splinting by licensed therapist, splint schedule to be provided from therapist to unit manager, training of staff for application and splint wearing schedule will be documented with staff	

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F 318	Continued From page 14 support on pillows; Provide PROM to bilateral upper and lower extremities for 15 minutes twice a day. 7/1/14 - 7/29/14 - Review of 14 OT Therapy Encounter Notes during this period documented: - R11 seen in response to change in ROM. - R11 resistive at times to gentle prolonged stretching and PROM especially elbow extension. - L elbow extension: severe at -80 degrees (severe 51-80)....was moderate at -30 in 2011. - RNP training with nursing staff for positioning arms in extension on pillows after PROM. 10/27/14 - OT Initial Evaluation for arm contracture management and postural alignment. R11 held arms in shoulder adduction [upper arm against side of body].... elbows flexed [bent upward] with hands fisted [fingers closed into palm]. Cognition recorded as "orientation x 0" within the cognition section of performance skills. R11's increased tone in the upper body was mostly abnormal motor responses to touch in the summary [resident tensed up when touched]. 10/27/14 - 11/24/14 - Review of 15 OT Therapy Encounter Notes discovered: - Precautions included severe dementia. - R11's wheelchair was set-up with side supports to keep resident upright, extended leg rest to avoid heel pressure and foot drop board for proper positioning. - PROM to arms required increased time and repeated attempts due to resident resistance, especially to left elbow stretch. - R11 was able to tolerate wearing the left elbow splint for up to 4 hours and 15 minutes. - RNP training with nursing staff completed for stretching techniques with PROM and left elbow	F 318	in-service sign in sheet maintained in the Nurse Practice Educator files, and splint screens to be completed quarterly to ensure splint is still appropriate. Education of therapy staff was completed on 3/8/17 (Attachment L). D. The Center Nurse Executive/designee will complete daily audits of residents with a footboard, splints or ROM (Attachment M) on 10% of the resident population until 100% compliance is achieved on 3 consecutive evaluations. Then audits will occur weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 318	Continued From page 15 splint use. 11/24/14 - Physicians' orders included a telephone order written by E17 (OT) order to discontinue OT services as of today. OT recommendation from 11/25/14 note for PROM for 10 minutes three times a day and left elbow splint for 4 hours from 7:00 PM to 11:00 PM was never ordered or implemented. 11/25/14 - Splint Wearing Instructions completed by E17 found in the OT section of the medical record documented the left elbow splint should be placed on the resident in the evening for 4 hours (7:00 PM - 11:00 PM). Stapled to this form was a Rehabilitation Communication Form dated 11/19/14 with the recommendation for RNP for PROM for 10 minutes three times a day and left elbow splint for 4 hours for evening shift. November and December, 2014 - CNA documentation showed in EMR that the resident received PROM twice a day. 4/16/15 - OT note documented R11 demonstrated good position in the wheelchair with foot drop board in high back wheelchair. 12/23/15 - NP monthly note documented the resident had a longstanding history of degenerative joint disease and spinal stenosis and the diagnosis of functional quadriplegia. 10/16/15 and 10/7/16: Comparison of Annual ROM Assessments discovered a decline in the left elbow going from moderate (range 25-50) to severe (range 51-80). The specific measurement (degrees) was not included on these forms.	F 318		

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F 318	Continued From page 16 January - February, 2017 - CNA documentation in the EMR showed the resident received PROM twice a day. 11/23/16 - NP monthly note documented the discussion of progression of dementia with the daughter who is in agreement that R11 was "in the late stages and has noted significant decline over the last year. Discussed palliative care consult in which daughter is in agreement with." 12/18/16: Quarterly MDS Assessment documented the resident had severe cognitive impairment, had unclear speech, was rarely understood/understands, had impaired range of motion of upper and lower extremities and received PROM every day of the 7-day look-back period. During an interview E18 (R11's evening shift CNA) on 2/13/17 at 3:45 PM when asked what splints the resident uses, E18 said "she uses boots, nothing for her arms". 2/13/17 (3:55 PM) - Observation of E18 and E19 (CNA) using a mechanical lift to get R11 into the wheelchair for dinner. The resident's arms were bent fully with both hands near the resident's face and a round pillow was between the arms and chest, hugging the pillow. The foot drop board was not placed on the wheelchair. 2/14/17 (8:25AM) - Observation of R11 in the wheelchair in the lounge area. Foot drop board not in place. During an interview with E17 on 2/14/17 at 9:20 AM about the status of elbow splint use, E17	F 318		

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F 318	Continued From page 17 checked the computer and verified that November 2014 was the last time the resident was seen by OT. E17 said the elbow splint recommendation should still be in place unless nursing had a reason for not using it. "That was the time when I got here and noticed that splints were ordered for the evening. I started recommending day time use so I can monitor their use." During an interview with E4 (RN, UM) on 2/14/17 at 9:56 AM to discuss R11's left elbow splint, E4 reviewed the care plan and could not find anything related to the elbow splint but would review the physician orders from that time period. E4 stated that the resident tenses up when you touch her and demonstrated squeezing both arms across the chest. When the surveyor showed the Splint Instructions document to E4, it was confirmed that was the first time that paper was seen by the unit manager. During an interview with E1 (NHA) on 2/14/17 around 4:00 PM, it was confirmed the recommendation for the left elbow splint was never written as an order in November, 2014. During an interview on 2/15/17 at 1:20 PM with E2 (DON), a copy of an OT note and ROM Assessment, completed by E17 the day prior, were presented to the surveyor. Review of the documents found the contractures of all joints remained the same as the 10/7/16 assessment with recommendations of PROM and positioning arms with pillows. The facility failed to implement a left elbow splint that was recommended on 11/25/14 for this resident with severe cognitive impairment,	F 318		

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F 318	Continued From page 18 functional quadriplegia and resistance to PROM. The facility also failed to implement the foot drop board on the resident's wheelchair. These findings were reviewed with E1 and E2 on 2/15/17 at 3:00 PM.	F 318		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to store food in accordance with professional standards for food	F 371	A. Residents residing in facility on 2/8/17 and 2/15/17 had the potential to be affected. There have been no foodborne	3/31/17

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F 371	Continued From page 19 service safety. Two observations were made of trays of ready to eat food stored in the walk-in refrigerator below trays of raw, ground meat. Findings include: An observation was made during the initial tour on 2/8/17 between 8:45 AM and 9:00 AM of a cart located on the right inside of the walk-in refrigerator with 3 trays of raw hamburger patties stored above a cake. An observation was made on 2/15/17 at 11:55 PM of a cart in the same walk-in refrigerator, with a tray containing bowls of pudding stored under a tray of raw beef. Findings were confirmed in an interview at the time of this finding with E7 (FSD). These findings were reviewed with E1 (NHA) and E2 (DON) on 2/15/17 at 3:00 PM.	F 371	illnesses at the facility. B. Residents residing in facility on 2/8/17 and 2/15/17 had the potential to be affected. There have been no foodborne illnesses at the facility. C. A root cause analysis was conducted on 2/20/17. A new process was developed for the walk in refrigerator. The speed rack closest to the door was labeled for use of "ready to eat" food items only. A second speed rack was labeled "raw" food items only. The bottom shelves of the second rack will be used for raw meats and egg products only. Education on the new process as well as the Food and Nutrition Services Policy and Procedures for refrigerated/frozen storage was completed by 2/26/17 (Attachment N). D. The Director of Dining Services/designee will complete daily walk-in refrigerator audits (Attachment O)three times a day until 100% compliance is achieved on 3 consecutive evaluations. Then weekly audits will occur until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	
F 514 SS=E	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514		3/31/17

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F 514	Continued From page 20 LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (I) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for 5 (R11, R64, R78, R162 and R182) out of 34 sampled residents the facility	F 514	A. R182 had all orders listed signed by the physician on 2/28/17. R64 and R162 February POS was corrected on 2/13/17.	

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F 514	Continued From page 21 failed to maintain accurate and complete clinical records. Findings include: 1. Review of the clinical record for R182 revealed: The following verbal / telephone orders (VO/TO) for R182 were not signed by the prescribing physician as of 2/14/17: 12/23/16 - Physician Order Sheet and Interim Plan of Care TO by E12 (MD) 12/23/16 - Physician's Orders for Bowel Protocol TO by E12 12/24/16 - Clarification Wound Care Orders VO by E12 12/26/16 - Clarification Speech Therapy Orders TO by E15 (MD) 12/27/16 - Clarification Physical Therapy Orders TO by E15 12/27/16 - Orders for a stat ultra sound of gallbladder TO by E12 12/2716 - 1/11/17 - multiple TO not signed by medical providers An interview on 2/14/17 at 9:38 AM with E20 (unit clerk) revealed that if the chart is tabbed with red flags the doctor still needed to sign the orders. E20 stated the doctor is faxed the order at the time the nurse writes it but the faxed copy is not returned to the facility instead the doctor will eventually come in and sign the orders. An interview on 2/14/17 at 10:08 AM with E21 (medical records clerk) revealed that there is a problem with the doctor signing the orders, she went on to say that this doctor is in the medical group with the facility's medical director and the medical director has not been able to get it to happen.	F 514	Current documentation for supplements is in place for R78. Monthly Functional Assessment for R11 was corrected on 2/20/17. B. Current residents have the potential to be affected. C. A root cause analysis was conducted on 3/6/17 on incomplete/inaccurate documentation. A consistent process for flagging the MAR is being developed for recording supplements. Education for nurses will be completed by 3/24/17 on the following: overall policy for documentation, process for documenting supplements, 24 hour chart checks, POS changeover checks (Attachment F). New physician (Dr. Areej Khan) started at Lofland Park Center on 2/28/17 and will be on-site Monday-Friday. Effective 3/6/17, she is accepting all new admissions for any patient/resident admitted to the facility that does not have a primary care physician that follows at facility. All orders will be signed by Dr. Khan ongoing to ensure physician documentation compliance. Medical Director was contacted and verified on 3/3/17 all charts will be current with physician signatures by 3/17/17. D. Center Nurse Executive/designee will complete daily audits of documentation (Attachment P & Q) in the clinical records on 10% of the resident population until 100% compliance achieved on 3 consecutive evaluations. Then audits will be completed weekly until 100%	

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F 514	Continued From page 22 2. Review of the clinical record for R64 revealed: On 1/25/17 a new order was written for R64 to receive pain medicine daily before morning care. Review of R64's January 2017 and February 2017 MAR's, indicated the pain medicine was given as ordered. Review of R64's monthly POS for February 2017 revealed that the new order for pain medication every morning before care initiated on 1/27/17 was not transcribed onto the February 2017's POS. During an interview on 2/13/17 at 2:27 PM with E4 (ADON), it was confirmed that the order for pain medication written on 1/27/17 failed to be transcribed on R64's monthly POS. E4 further explained that a final review should have been done on the 31st and checked for accuracy. 3. .Review of the clinical record for R162 revealed: On 1/27/16 an order was written that decreased R162's medication that was used to calm or assist with sleep. Review of R162's January 2017 and February 2017 MAR's, indicate the medication was given as ordered. Review of R162's monthly POS for February 2017 revealed that the decreased order for R162's sleeping medication, initiated on 1/27/17, was not transcribed onto February 2017's POS. During an interview on 2/13/17 at 2:27 PM with E4 (ADON), it was confirmed that the order that decreased R162's sleeping medication, written on	F 514	compliance achieved on 3 consecutive evaluations, and then monthly until 100% compliance achieved on 3 consecutive evaluations. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.	

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F 514	Continued From page 23 1/27/17, failed to be transcribed on R162's monthly POS. E4 further explained that a final review should have been done on the 31st and checked for accuracy. 4. Review of the clinical record for R78 revealed: On 5/19/16 an order was written for R78 to receive a protein supplement three times a day to assist in healing of a wound. On 10/31/16 an order was written for R78 to receive a different brand of protein supplement two scoops daily once supply of previous supplement is exhausted. Review of R78's MAR's revealed the absence of documentation of administration of the protein supplement on: July 3 and 7 of 2016, October 4, 5, 11, 17, 21, 25 and 27 of 2016, November 7, 13, 19 and 20 of 2016, December 3, 4, 5, 12, 16, 17 and 18 of 2016, and January 16, 26 and 19 of 2017. During an interview on 2/14/17 at 11:52 AM with E4, it was confirmed that the protein supplement was given to R78 as ordered, but was not documented. During an interview on 2/14/17 at 2:10 PM with E11 (LPN), it was confirmed that on dates when R64 was assigned to her that the protein supplement was administered as ordered but it was not signed off. Cross Refer F318 5. Review of R11's clinical record revealed: October 2014 Annual ROM Assessment - form was not able to be located in R11's current or	F 514		

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F 514	Continued From page 24 thinned record. 10/27/14 OT Initial Evaluation - conflicting information about R11's cognitive functioning. Cognition recorded as "orientation x 0" within the cognition section of performance skills, but in the same document recorded as "AO x 3, unable to arouse." 4/16/15 - OT note referred to R11 using a left elbow splint which was never ordered or obtained in November 2014 for R11. 1/11/17 - nursing note documented the resident had a pressure ulcer to right heel. 1/18/17 Monthly Functional Assessment - "None" documented in pressure ulcer section even though R11 had a heel blister pressure ulcer. These findings were reviewed with E1(NHA) and E2(DON) on 2/16/17 at 3:00 PM.	F 514		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Lofland Park

DATE SURVEY COMPLETED: February 15, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and complaint survey was conducted at this facility from February 8, 2017 through February 15, 2017. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was 106. The survey sample totaled thirty four (34).	
3201	**Regulations for Skilled and Intermediate Care Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 15, 2017: F0272, F0309, F0314, F0318, F0371, F0514.	Cross reference to the CMS-2567 (02-99) survey: F0272, F0309, F0318, F0371, F0514.

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

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3201.9.0 **3201.9.6** **3201.9.8** **3201.9.8.4** **3201.9.8.4.3**	Records and Reports All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence. Reportable incidents are as follows: Significant injuries. Areas of contusions or bruises caused by staff to a dependent resident during ambulation, transport, transfer or bathing. Based on record review, interview and review of facility documentation, it was determined that for one (R11) out of 34 sampled residents the facility failed to report three reportable incidents to the State Agency (DLTCRP). Findings include: The following was reviewed in R11's clinical record: R11 is a dependent resident with advanced dementia and: 1. On 5/5/16 at 6:30 PM, while staff was transferring R11 to bed, R11's lower leg was bumped against the mechanical lift sustaining a 3 cm by 2.5 cm discoloration to left lower shin. 2. On 6/10/16 at 7:00 PM, while staff attempting to transfer R11 with the mechanical lift, they observed a 1 cm by 1 cm skin tear on the left elbow. 3. On 1/30/17 at 7:30 PM, while providing care to R11 around/after the time the resident is usually transferred back to bed with the mechanical lift, staff noticed a 1 cm x 1 cm abrasion on left elbow. Resident unable to state how abrasion occurred. During an interview on 2/14/17 at 12:40 PM,	A. State reports were made for R11 on all 3 incidents listed on 3/7/17. B. Current resident incident reports were reviewed back to February 8, 2017 and State reports were made for any resident meeting reportable incident guidelines on 3/7/17. C. Education of State reportables will be completed for staff completing RMS (facility incident report system) by 3/24/17 (Attachment A). The Assistant Director of Nursing/designee will review incidents ongoing to verify State reportables have been completed. D. The Center Nurse Executive/Designee will complete audits (Attachment B) of all RMS incidents until 100% compliance occurs on 3 consecutive evaluations. Then audits will be completed weekly until 100% compliance is achieved on 3 consecutive evaluations, and then monthly until 100% compliance is achieved on 3 consecutive evaluations. Results of audits will be presented to the Quality Assurance Performance Improvement Committee for review and recommendations.

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	E1 (NHA) confirmed that these three incidents had not been reported to the State Agency (DLTCRP). These findings were reviewed with E1 and E2 (DON) on 2/15/17 at 3:00 PM.	

Provider's Signature Tawnya Lemm, EdD, NHA Title Center Sr. Executive Director Date 3/10/17